The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Prairie States Enterprises at 800-615-7020. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 800-615-7020 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: **$1,600** Individual / **$3,200** Family; For out- of-network providers **$3,000** Individual / **$6,000** Family Does not apply to preventive care. BSD contributes $500 HSA dollars/individual BSD contributes $1,000 HSA dollars/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care when rendered by network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers **$3,000** Individual / **$6,000** Family; For out- of-network providers there is no maximum. Includes the deductible, coinsurance and copayments	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, amounts over usual and customary fees, pre-certification penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. The Alliance and Trilogy: www.the-alliance.org or www.trilogycares.com or call Customer Service at 1-800-223-4139 Out-of-area: First Health Network www.firsthealth.com or call 1-800-226-5116	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	This plan will allow you to see a specialist of your choice without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $20 copayment, then 5% coinsurance	Deductible, then 30% coinsurance	BHS will waive copayment for services provided to any individual covered under the Beloit School District health plan, except emergency room copayment
	Specialist visit	Deductible, then $20 copayment, then 5% coinsurance	Deductible, then 30% coinsurance	BHS will waive copayment for services provided to any individual covered under the Beloit School District health plan, except emergency room copayment
	Preventive care/screening/ immunization	Deductible waived, 0% coinsurance, no copayment	No Coverage	Well Child Care examinations and routine related lab. Includes state-mandated immunizations Routine Physical Examinations applies to covered persons age 7 and over. Routine Mammograms limited to one per plan year beginning at age 40. Routine PSA Testing limited to one per plan year beginning at age 40. Routine Pap Smear limited to one per plan year. Routine Colonoscopy limited to 1 every 5 years. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	Imaging Requires Preauthorization. Failure to do so will result in a 25% Penalty up to $250.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from at http://www.flexscripts.com or 1-800-603-7796	Generic drugs (Tier 1)	Deductible then: $7 copayment Retail 34-day supply $14 copayment Retail 35-68-day supply $21 copayment Retail 69-102-day supply $21 copayment Mail Order up to 102-day supply	Not Covered	Specialty Drugs over $1,500 for a 30-day supply require additional Plan Authorization by contacting the Pharmacy Benefit Administrator at 1.800-603.7796 Optional ScriptSourcing Savings Program is available. For more information, please see plan document. If eligible for savings, lack of participation in ScriptSourcing will result in a 50% copay after the second fill.
	Preferred brand drugs (Tier 2)	Deductible then: $16 copayment Retail 34-day supply $32 copayment Retail 35-68-day supply $48 copayment Retail 69-102-day supply $48 copayment Mail Order up to 102-day supply	Not Covered	
	Non-preferred brand drugs (Tier 3)	Deductible then: 50% copayment Retail 34-day supply 50% copayment Retail 35-68-day supply 50% copayment Retail 69-102-day supply 50% copayment Mail Order up to 102-day supply	Not Covered	
	Specialty drugs (Tier 4)	Call FlexScripts	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	Preauthorization is required. If you don't receive Preauthorization, benefits will be reduced by 25% up to a maximum of $250.
	Physician/surgeon fees	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Deductible then $75 copayment then 5% coinsurance	Deductible then $75 copayment then 5% coinsurance	Copayment is waived if admitted. Copayment shall apply regardless if deductible is met
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible 20% coinsurance	If medically necessary the out of network ambulance charge will be paid at the in-network benefit level
	Urgent care	Deductible then $30 copayment then 5% coinsurance	Deductible, then 30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	Preauthorization is required. If you don't receive Preauthorization, benefits will be reduced by 25% up to a maximum of $250.
	Physician/surgeon fees	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then $20 copayment then 5% coinsurance	Deductible, then 30% coinsurance	BHS will waive copayment for services provided to any individual covered under the Beloit School District health plan, except emergency room copayment. Preauthorization is required for inpatient hospitalizations. If you don't receive Preauthorization, benefits will be reduced by 25% up to a maximum of $250.
	Inpatient services	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	
If you are pregnant	Office visits	Deductible then $20 copayment then 5% coinsurance	Deductible, then 30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Dependent pregnancy covered.
	Childbirth/delivery professional services	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	
	Childbirth/delivery facility services	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible, then 30% coinsurance	Limited to 40 visits per plan year. Preauthorization is required. If you don't receive Preauthorization, benefits will be reduced by 25% up to a maximum of $250.
	Rehabilitation services	Deductible then $20 copayment then 5% coinsurance for Occupation/Physical/Speech Therapy. Deductible then 5% coinsurance for all other covered Rehabilitation services.	Deductible, then 30% coinsurance	Occupational/Physical/Speech Therapy Preauthorization is required. If you don't receive Preauthorization, benefits will be reduced by 25% up to a maximum of $250.
	Habilitation services	Covered	Covered	Covered.
	Skilled nursing care	Deductible then 5% coinsurance first 30 days than 20% coinsurance next 90 days	Deductible, then 30% coinsurance	Skilled Nursing Inpatient maximum 120 visits per plan year. Preauthorization is required. If you don't receive Preauthorization, benefits will be reduced by 25% up to a maximum of $250.
	Durable medical equipment	Deductible then 20% coinsurance	Deductible, then 30% coinsurance	Preauthorization is required. If you don't receive Preauthorization, benefits will be reduced by 25% up to a maximum of $250.
	Hospice services	Deductible then 5% coinsurance	Deductible, then 30% coinsurance	Inpatient Hospice Preauthorization is required. If you don't receive Preauthorization, benefits will be reduced by 25% up to a maximum of $250.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery and/or weight loss programs
- Cosmetic Surgery
- Routine Dental Care (Adult & Child)
- Infertility Treatment
- Long-Term Care
- Habilitation Services
- Holistic Medicine

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Oral Surgery
- Chiropractic Care
- Contraception Services
- Cochlear Implants
- Autism Spectrum Disorder

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: : the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-615-7020.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-615-7020.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-615-7020.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-615-7020.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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* For more information about limitations and exceptions, see the plan or policy document by calling your Human Resources Dept or Prairie States.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1600**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **5%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$10
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,270**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1600**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **5%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$1,600
Copayments	$400
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,050**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1600**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **5%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$1,600
Copayments	$200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,820**

The plan would be responsible for the other costs of these EXAMPLE covered services.